THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Chemsex

Crystal meth, GHB/GBL, and mephedrone or other cathinones, with occasional ketamine, cocaine, or alcohol around them. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. GHB is the medical emergency in this pattern.** If you dose GHB or GBL more than three or four times a day, or overnight to prevent withdrawal, do not stop on your own: withdrawal can cause fatal seizures and delirium within hours. Go to an emergency department. There is no antidote for GHB, and naloxone does not work on it.
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> **Call 911** for someone who is unresponsive or breathing slowly, for chest pain or stroke signs, for a seizure, for dangerously high body temperature, or for escalating paranoia or hallucinations. A stimulant can hide GHB's sedation: someone who seems to be sleeping can stop breathing hours later. Never combine GHB with alcohol or ketamine.
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> **After a possible HIV exposure, PEP works only within 72 hours.** Ask any emergency department or sexual health clinic. Drug-facilitated sexual assault happens in these settings, and you have the right to care regardless of what you took (RAINN: 1-800-656-4673).
>
> **The meth crash carries a genuine suicide-risk window,** especially in days 1 to 5. Call or text 988, or text HOME to 741741. The Trevor Project (LGBTQ+): 1-866-488-7386. · SAMHSA: 1-800-662-4357 · Never Use Alone: 1-800-484-3731

1. Before you start

This is a route through the Recovery Kernel for people whose chemsex pattern has become a problem, and for the people supporting them. The Kernel's framing is that chemsex is not three separate addictions. It is one pattern organized around a context (sexual experience) and a community, expressed through several substances that each play a role. Meth is the engine of energy and sexual drive. GHB smooths the stimulant edge and lowers inhibition. Mephedrone and other cathinones ("cat") supply emotional warmth and touch. This guide follows that logic, and it does not ask you to leave your community or your sexual identity. Six rules set the order of everything that follows.

- **GHB is the medical priority.** Of the three, it has the most dangerous withdrawal. Address it first. Meth and cathinone withdrawals are brutal but not medically dangerous in the same way, and they run in parallel.
- **The mixes kill more than the single substances.** GHB with alcohol and GHB with ketamine are both listed by the Kernel as fatal combinations. Meth can mask GHB's sedation and delay respiratory arrest by 2 to 6 hours. Cocaine with alcohol forms cocaethylene.
- **Treat the whole pattern on one plan.** Three or more tracks, one coordinated schedule, with the sexual health assessment in the first week.

- **Screen for psychosis risk.** If you have a personal or family history of psychosis, schizophrenia, or bipolar disorder, the Kernel calls further stimulant use a genuine contraindication. Ask for a psychiatric evaluation.
- **The timeline is long.** Meth dopamine repair can take 12 to 24 months, GHB receptor recovery 12 to 18 months or more. Expecting weeks is how people conclude, wrongly, that recovery has failed.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supplemental Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 29 (How to Recover from Chemsex). It coordinates the substance chapters: Chapter 10 and 31 (GHB), Chapter 11 and 32 (methamphetamine), Chapter 15 and 33 (3-MMC), Chapter 17 (other cathinones), Chapter 23 (ketamine), Chapter 12 (cocaine), Chapter 8 (alcohol). Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** The chemsex, GHB, and meth chapters cite Compendium protocols by number, and some numbers do not match the Compendium as printed. They call Protocol 05 "environmental redesign" (printed: Digital Detox), Protocol 06 "Daily Structure" (printed: Phenotype Assessment), Protocol 20 "identity reconstruction" (printed: Mapping the Terrain), and Protocol 04 "Dharma Recovery" (printed: Meeting Alternatives). Chapter 29's "Protocol 42" for HIV prevention is printed as Deploying Anti-Viral Firewalls, but the Compendium also prints a different Protocol 42, The Experimental Branch. The "Protocol 35S series" for chemsex is not in the provided text: use Supp. Ch. 29 instead. This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> In chemsex settings, redosing decisions made alone, or made to keep pace with a session rather than a felt medical need, are this guide's most dangerous moment.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as "the plan must be wrong," answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: GHB dependence, fatal combinations, cardiac and psychosis signs, PEP window.	Supp. Ch. 29 §0 Supp. Ch. 10 §0; Ch. 31 §§0, 7 Main Book App. A (interaction matrix)

Step	When	What you do	Turn to
1	Days 0–7	GHB detox first, in medical care. Then the crash and cathinone comedown. Sexual health assessment.	Supp. Ch. 29 §§1, 3, 5.1 Supp. Ch. 31 §§1–2, 8 Supp. Ch. 32 §§0, 2
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3, 4
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 29 §2 Compendium P06
4	Weeks 2–6	Resolve your combined profile. Screen for the psychosis-risk profile.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 29 §2 Supp. Ch. 32 §6
5	Day 1 post-detox to Month 6	Build the unified biological foundation with your physician.	Supp. Ch. 29 §4 Supp. Ch. 10 §4; Ch. 32 §8 Compendium P07, P09, P17, P18
6	Days 1–30, then ongoing	Apps down in 24 hours. Plan weekends. Learn the chemsex craving interrupt.	Supp. Ch. 29 §7 Supp. Ch. 10 §5 Compendium P05, P08, P33
7	Week 1, then lifelong	Sexual health: testing, PrEP or ART, the flatline, sober intimacy.	Supp. Ch. 29 §§5–6 Compendium P42 (Anti-Viral Firewalls)
8	Weeks 2–12, then years	Sober community, identity, inventory, work, family.	Supp. Ch. 29 §8 Supp. Ch. 42, 43, 39, 51 Compendium C-28, P04, P08, P16, P24
9	Whenever it arises	The occasional extras: alcohol, ketamine, cocaine. A break is not a reset.	Supp. Ch. 8, 23, 12 Supp. Ch. 32 §3 Main Book App. A
10	Year 1 to Year 10	Steward: review, transplant, mentor.	Supp. Ch. 44, 6, 38 Compendium P02, P13 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

GHB first. Answer these honestly: are you dosing GHB, GBL, or 1,4-BD more than three times a day; do you shake, sweat, or feel extreme anxiety when you miss a dose; have you ever had a seizure, confusion, or hallucinations without it; are you dosing every two hours or overnight; do you also use alcohol or benzodiazepines regularly? A yes to any means medical detox, not self-management. If you answered no to all, you may be at a lower level, and the Kernel's five-level pattern classification (Supp. Ch. 31 §7) says a same-day physician conversation is still the responsible move before stopping.

The combinations. The Kernel's interaction matrix lists GHB with alcohol as fatal (both are GABA-B agonists, with no antidote), GHB with ketamine as fatal (rapid respiratory failure and loss of airway protection), and methamphetamine with GHB as fatal (the stimulant masks the sedation, so you underestimate the GHB load, and respiratory arrest can follow 2 to 6 hours later while you appear to be sleeping, needing 12 or more hours of monitoring). Cocaine with alcohol creates cocaethylene, which is more cardiotoxic than either alone. Fentanyl now contaminates supplies beyond opioids, so carry naloxone regardless: it does not work on GHB, but other substances may be present that you did not know you took.

Other emergencies. Meth cardiac events and stroke (chest pain, irregular heartbeat, jaw or arm pain, severe headache, facial drooping) and psychosis (paranoid delusions, hallucinations) need 911. Mephedrone and cathinone overdose brings chest pain, high blood pressure, high body temperature, seizure, and agitation: call 911 and cool the person. Injection emergencies include fever with shaking chills, or chest pain with fever, which can mean septicemia or endocarditis. Do not wait and see.

Turn to: Supp. Ch. 29 §0 (medical emergencies by substance; HIV and STI emergency response; naloxone). Supp. Ch. 10 §0 and Supp. Ch. 31 §§0 and 7 (who needs medical detox; use-pattern levels). Main Book, Appendix A (drug interaction matrix). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Medical sequencing (Days 0–7)

The Kernel's sequencing principle: address GHB first, establish the medical and supplement framework for all three, then build the behavioral and relational architecture. In the first 72 hours, GHB is the only track that matters. Withdrawal begins 2 to 6 hours after the last dose in a dependent user, the peak-danger window runs roughly 12 to 72 hours, and there is no FDA-approved treatment specific to GHB. The Kernel presents baclofen as the most evidence-supported option, with high-dose benzodiazepine protocols commonly used. It does not give a self-administered protocol, and neither does this guide. Meanwhile the meth crash brings extreme exhaustion, hypersomnia, hunger, and depression, and the cathinone comedown brings depression, anxiety, and fatigue. Allow them: sleep, eat, hydrate. The meth "Pit" in days 1 to 5 is also the highest relapse and suicide-risk window, so avoid being alone and reach out early.

> **The 30-day cliff.** A common discharge pattern is about 5 days inpatient followed by a benzodiazepine supply of about 30 days as a bridge. When that supply ends on a calendar date, with no taper and no follow-up booked, relapse is documented and common, because the GABA-B system is still months from recovery. Before you leave: book an outpatient appointment dated before the supply runs out, and ask for a taper, not a hard stop. (Supp. Ch. 31 §8)

Add these to the first week: HIV testing (and PEP if within 72 hours of a possible exposure); an STI panel with urethral, rectal, and pharyngeal swabs; syphilis, herpes, hepatitis B and C testing; hepatitis B and HPV vaccination status; mpox vaccination if you are not immune and in an endemic area; an ECG and blood pressure check if you used significant meth or cathinones; and liver and kidney function, especially for GBL users. If you used cocaine, ask for a complete blood count for levamisole. If you have bladder symptoms from ketamine (frequency, urgency, pain, blood in urine), see a urologist first, before any supplement plan.

Turn to: Supp. Ch. 29 §1 (the polydrug withdrawal reality), §3 (sequenced detox; combined timeline), §5.1 (the sexual health medical assessment). Supp. Ch. 31 §§1–2 and 8 (why GHB withdrawal is different; timeline; detox options; the 30-day cliff). Supp. Ch. 32 §§0 and 2 (the meth crash timeline and safety). Supp. Ch. 33 §§0 and 8 if 3-MMC is your cathinone. If you also use alcohol or benzodiazepines: Supp. Ch. 8, Ch. 9, and Ch. 30.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior profile is the Kernel's primary chemsex driver), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A (including the interaction matrix) and Appendix B are reference.

Then add: Supp. Ch. 4 (The Braking System: GABRA2 and GABRB3), which matters for GHB. Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no chemsex case study, but Case 10 (GHB), Case 05 (methamphetamine), and Case 15 (polydrug) are the nearest profiles. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

The chemsex panel in Supp. Ch. 29 §2 lists: **COMT** (Val/Val, the primary chemsex driver), **MTHFR**, **GABRA2** (for GHB dependence, withdrawal, and seizure risk, essential for your medical team), **DRD2/ANKK1**, **DAT1/SLC6A3** (linked to ADHD, and meth self-medication is a documented pathway), **SLC6A4**, **CYP2B6** (poor metabolizers accumulate GHB and norketamine, and need lower baclofen doses), and **FAAH**. Add MAOA and BDNF from the meth guide, and CYP2C19 and CYP3A4 for baclofen and benzodiazepine metabolism. ADH1B and ALDH2 matter if you used 1,4-BD. Test GABRA2 as early as possible.

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 29 §2 (the DNA panel for chemsex recovery). Supp. Ch. 10 §2 and Supp. Ch. 32 §6 (GHB and meth gene tables). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your combined profile (Weeks 2–6)

The Kernel names two vulnerabilities for chemsex specifically: COMT Val/Val (a fast-clearing brain that seeks intensity, sexual novelty, and risk to reach an adequate dopamine signal) and MTHFR variants (which it links to compromised mucosal integrity and impaired neurotransmitter synthesis). Write your profile down and carry key results on a card.

If your result is...	What changes	Source
COMT Val/Val (Warrior)	Low baseline dopamine; drawn to intensity. Leaving chemsex without building equivalent intensity risks relapse from neurobiological necessity, not moral failure. Meth crash presents as flatness and boredom.	Supp. Ch. 29 §2; Ch. 32 §6
COMT Met/Met plus psychosis history	The Kernel's genetically contraindicated profile for meth: a pure dopamine flood into a high-tone system, with risk of a psychotic disorder that may not fully resolve. Ask for a psychiatric evaluation before any further use.	Supp. Ch. 32 §6
GABRA2 high-risk	Weak inhibitory brake. GHB relief is extraordinary for this genotype. Slower taper, more severe PAWS, higher seizure risk. Alcohol with GHB is the "Hard Fail."	Supp. Ch. 10 §2; Ch. 29 §2
MTHFR variants	5-MTHF addresses both the mucosal integrity concern and the neurotransmitter deficit. Non-optional for carriers. Avoid synthetic folic acid with any T variant.	Supp. Ch. 29 §2; Main Book Ch. 2
DRD2 A1 and DAT1 10-repeat	Reduced D2 density and faster reuptake. Build several reward sources at once. Ask about an ADHD evaluation, since meth may have been self-medicating.	Supp. Ch. 29 §2

If your result is...	What changes	Source
SLC6A4 short/short	High anxiety and shame sensitivity; strongest pull from mephedrone's and MDMA's serotonin effects. Serotonin rebuilding is co-primary with dopamine.	Supp. Ch. 29 §2
CYP2B6 poor metabolizer	GHB and norketamine accumulate; dependence may develop faster and at lower doses. Baclofen needs lower doses and closer monitoring. Tell the detox team.	Supp. Ch. 29 §2
CYP2C19 / CYP3A4	Affect how baclofen and benzodiazepines are metabolized in GHB detox. Tell the treating physician of any known result.	Supp. Ch. 10 §2; Ch. 31 §5

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 29 §2. Supp. Ch. 32 §6 (including the plain-history screen for psychosis risk). Main Book Ch. 5 and Appendix A.

Step 5 — Build the unified biological foundation (Day 1 post-detox to Month 6)

The Kernel's unified stack rebuilds three systems at once: GABA-B function for GHB, dopamine synthesis and D2 density for meth, and serotonin tone for mephedrone and MDMA, all on a methylation foundation. Its priorities: methylation and B6 (which the Kernel calls non-negotiable across all three tracks), magnesium from day 1, NAC across all tracks, dopamine precursors starting around day 3 to 5 once eating regularly, a receptor-rehabilitation stack for dopamine, serotonin support in the evening, and anxiety and sleep support during the GHB recovery. Two cautions matter. Do not add GABA-supporting supplements during a baclofen or benzodiazepine taper without your physician, because some add sedation. And some items, such as taurine, come only after the GHB taper is underway.

There is no FDA-approved medication for meth or cathinone withdrawal. The Kernel notes that "ghost scaffolding," psychiatrist-supervised, time-limited stimulant stabilization, exists in some specialist programs. It labels this Emerging evidence, specialist-only, and not a self-directed strategy, and you should treat it that way. The dose tables are in the chapters below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape). The peptide layers are labeled by the Kernel as needing physician discussion, so they are not self-start steps.

Turn to: Supp. Ch. 29 §4 (the unified stack: methylation, integrated neurotransmitter stack, peptide layer). Supp. Ch. 10 §4 (GHB reconstruction and the medication-timing cautions). Supp. Ch. 32 §8 (meth recovery protocol). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), Protocol 09 (The Gut-Brain Axis), Protocol 07 (Neuroplasticity), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Apps, weekends, and the craving (Days 1–30, then ongoing)

The chemsex craving is for a complete state, not a single drug: the sexual intensity, the disinhibition, the belonging, the escape. So it has many triggers. The Kernel names sexual arousal (the conditioned link between arousal and the chemsex state), apps (the primary access pathway), the weekend session times, loneliness, stress and rejection, and people from the scene. Its practical rules: the apps must come down within the first 24 hours, not eventually, and stay down for at least 90 days; pre-plan every Friday and Saturday in the first six months with structured, high-intensity alternatives, because the craving can appear at those hours months into recovery; and use block and mute functions on scene contacts as protection, not cruelty. Some of those relationships can be kept in sober contexts later, but most cannot be kept safely in early recovery.

The chemsex 5-minute interrupt: name the whole object of the craving (intensity, belonging, escape, intimacy); exit the environment or platform; six cycles of 4-7-8 breathing; your supplements; a contact who understands chemsex recovery; a high-intensity natural reward; then document it. GHB cravings add their own types (anxiety-driven, sleep-context waking at the old dosing times, social cue, and flat anhedonic craving), and keeping a large supply on hand is its own risk factor.

Turn to: Supp. Ch. 29 §7 (chemsex craving triggers and the 5-minute interrupt). Supp. Ch. 10 §5 (the four GHB craving types). Supp. Ch. 31 §7 (hoarding a supply). Compendium Protocol 05 (Digital Detox), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect), Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse).

Step 7 — Sexual health and sober intimacy (Week 1, then lifelong)

The sexual health track runs for the entire recovery, not just early recovery. If you are HIV-negative: PrEP before any further sexual activity, PEP within 72 hours of a possible exposure, regular HIV testing, and hepatitis C monitoring if you injected (it is curable). If you are HIV-positive: undetectable equals untransmittable (U=U), and if chemsex disrupted your medication adherence, ask about long-acting injectable options. STI testing at least every three months for the first year.

Expect the "flatline": early recovery often brings a silence where desire once lived, roughly 1 to 3 months after meth-primary patterns and 3 to 6 or more after frequent MDMA. The Kernel's instruction: do not panic, do not test, do not force. This is a season, not a verdict, and checking whether function has returned delays it. For many people the first sober sexual experience is not a return but a first, because every intimate encounter was chemically mediated. The nervous system never learned contact without buffers. Begin with non-sexual touch and lower-stakes intimacy, and expect sexual shame, which predated chemsex and may need LGBTQ+-affirming therapy.

Turn to: Supp. Ch. 29 §5 (sexual health and recovery: the medical assessment, the chemical intimacy trap, the flatline, rebuilding sober sexuality) and §6 (HIV and health management). Compendium Protocol 42 (Deploying Anti-Viral Firewalls), and the two protocols the Compendium prints as Protocol 15 (The Intimacy Reboot; Sexual Restoration).

Step 8 — Community, identity, and rebuilding a life (Weeks 2–12, then years)

Removing the substances without replacing the community function produces isolation, and isolation is where relapse incubates. The Kernel's answer is a sober version of what the scene provided, built inside the queer community, not outside it: Crystal Meth Anonymous, SMART Recovery LGBTQ+ meetings, chemsex-informed health services and therapy (which it calls the most valuable clinical relationship in this recovery), and sober social spaces and sports leagues. If your adult sexual identity formed inside chemsex, sobriety does not restore a previous self; it builds one. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. If trauma or a history of loss is part of your story, sequence trauma-processing after biological stability.

Turn to: Supp. Ch. 29 §8 (community, identity, and the architecture of sober belonging). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Centurian Paper C-28 (The Recast). Compendium Protocol 04 (Meeting Alternatives), Protocol 08 (Social Environment), Protocol 16 (The Isolation Spiral), Protocol 23 (Rebuilding the Ledger), Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 9 — The occasional extras: alcohol, ketamine, cocaine

Alcohol and wine. The Kernel lists GHB with alcohol as fatal, and it calls GABRA2 high-risk carriers a "Hard Fail" profile for combining alcohol with GABAergic agents. Alcohol with cocaine forms cocaethylene. Alcohol is also a poor substitute in recovery: using it to fall asleep suppresses REM sleep, the stage where repair happens, slows dopamine recovery, and can start a second dependence. The Kernel calls alcohol-to-benzodiazepine transfer the most dangerous addiction transfer, and says cannabis transfer is common for anxious drinkers. Heavy caffeine has a milder version of the same problem, through sleep.

Ketamine. With GHB it is listed as fatal. There is no antidote, and a k-hole is a medical emergency in itself (vomiting while unresponsive risks aspiration). If you have bladder symptoms (frequency, urgency, pain, blood in urine), see a urologist first. Ketamine-associated bladder damage is progressive, and stopping is the only way to halt it. The Kernel notes genuine research interest in ketamine for stimulant use disorder but calls it Emerging evidence, specialist-supervised only, and worth real caution, because a second dissociative substance can become compelling to the same reward-deficiency vulnerability.

Cocaine. It causes heart attacks and strokes at any age through coronary spasm. Most of the supply carries levamisole, so fever, mouth sores, or a severe sore throat need a same-day blood count. There is no reversal agent.

A break is not a reset. The Kernel says a period of real abstinence repairs receptors, but tolerance is genuinely lost, and the old pathways are quieter, not deleted. Returning to a "known" amount after a break is dosing a body whose capacity has changed, which is the mechanism behind the elevated cardiac and overdose risk seen in relapse after abstinence. Relapse after a break can also escalate faster than the original use did.

Turn to: Supp. Ch. 8 (Alcohol), especially §3 and §8. Supp. Ch. 23 (Ketamine), §0 and §1.4. Supp. Ch. 12 (Cocaine), §0. Supp. Ch. 32 §3 (the substitutes, and "the fracture": why a year off is not a reset). Main Book Appendix A (interaction matrix). Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer).

Step 10 — The long game (Year 1 to Year 10)

The Kernel maps the first 12 to 24 months of chemsex recovery in detail. After that, navigation shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02. Compendium Protocol 13 (The Pharma Trap, a regular review of whether each medication is still needed). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	GHB detox first; heart check; no mixing	Close out bridge medication with a taper [1]	Tell every prescriber	No mixing, no stockpile, ever [7]
Biology and genome	GABRA2, COMT; unified stack	Retest labs; step stack to upkeep [2]	Prescriber card: GABRA2, CYP2B6	Re-check with new meds and age
Apps, venues, cues	Apps down in 24 hours; venues, contacts	Weekends planned; apps stay down	Reinstating apps is a deliberate call [5]	Same plan, rehearsed
Intensity and natural calm	Hard exercise; breath, cold	Own GABA and dopamine carry on [3]	Several intense outlets	Practice still daily
Sleep, mood, three tracks	Crash, sleep; three tracks, one plan	Flatline over; sleep restored	Mood plan, clinician-led	Stress plan, sleep habits
Sexual health and intimacy	Tests, PrEP; flatline season	Sober intimacy being learned	Routine testing, PrEP or ART	Routine testing, lifelong
Community and Manning	Sober community: CMA, SMART	Transplant; inventory, work [4]	Manning: mentor, peer support [6]	Mentor or run a group

The seven shifts

1. **Year 3, close out the bridge.** If a benzodiazepine or baclofen bridge was part of your GHB recovery, it should now have ended with a clinical taper, not a calendar date (Supp. Ch. 31 §8). From here, any new anxiety gets evaluated as anxiety with the GHB history disclosed, and any prescription carries a review date (Compendium Protocol 13).
2. **Year 3, the stack moves from building to upkeep.** GABA-B receptor recovery reaches substantial completion around 12 to 18 months, and meth D2 receptor recovery takes 12 to 17 months (Supp. Ch. 31 §2; Ch. 32 §3). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, your own GABA and dopamine carry on.** The Kernel describes a different baseline: a nervous system regulating itself again and near-normal hedonic capacity (Supp. Ch. 10 §3.3; Ch. 29 §3). Breathwork, cold, exercise, and stillness become ordinary life.

4. **Year 3, meaning moves up.** As the repair tracks drop to maintenance, redirect the devotion and daily structure the pattern required into a practice (Supp. Ch. 44) and return to work (Compendium Protocol 24).
5. **Year 5, reinstating apps or scene contact becomes a deliberate decision.** The Kernel says apps should not be reinstated while chemsex recovery is still consolidating (Supp. Ch. 29 §7). By year 5, whether and how to return to dating apps and social spaces is a decision made in advance, away from a craving, with a plan and a person who knows.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). The Kernel calls the chemsex-informed therapist the most valuable clinical relationship and describes peer communities such as Crystal Meth Anonymous (Supp. Ch. 29 §8), so mentoring and peer support have real value here.
7. **Year 10, no mixing, no stockpile, and no "known amount."** GHB has no antidote, stimulants hide its sedation, and GHB with alcohol or ketamine can be fatal. The Kernel also says a long break does not reset tolerance: returning to a familiar amount is where cardiac and overdose risk concentrates (Supp. Ch. 32 §3; Ch. 31 §7; Main Book Appendix A).

What is sourced and what is extrapolated. *Shifts 1, 3, and 7 rest directly on Kernel text. Shifts 2 and 6 apply Kernel rules at a timing chosen for this guide. Shifts 4 and 5 are extrapolations, with 5 partly sourced. The Kernel's detailed chemsex timeline ends at about 12 to 24 months, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with GHB triage and supervised detox first, the sexual health assessment in week 1, the unified biological foundation, the apps and weekends redesigned, sober intimacy and community built, and then identity and purpose work, this is the outcome the Kernel projects:

- **You get through the medical window.** The GHB detox is supervised, the meth crash and cathinone comedown are ridden out with support, and the bridge medication ends by taper with follow-up booked.
- **Months 1 to 3:** the GABA system substantially recovers, D2 receptors measurably upregulate, and sexual response begins to return, which may feel confusing without the chemical context.
- **Months 3 to 12:** the GHB track is largely complete with an appropriate taper, dopamine is at or near baseline, the serotonin baseline is recovered, the flatline resolves, and the compulsive link between meth and sex weakens.
- **Beyond one year:** meth's substantial D2 recovery takes 12 to 17 months, GHB receptor recovery 12 to 18 months or more. The Kernel describes the result as a different baseline, not just symptom absence.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk or that a return to use cannot happen. It states that chemsex is the most complex recovery in its series, that GHB has no antidote, and that treating any one substance in isolation underestimates the timeline.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Get through the medical window	Hours 0–72	GHB withdrawal managed in medical care (the only track that matters in this window). Meth crash and cathinone comedown ridden out.	Supp. Ch. 29 §3; Ch. 31 §2	Clinical fact
The Pit	Days 1–5 (meth)	Severe depression and anhedonia. The highest relapse and suicide-risk window. Do not be alone if avoidable.	Supp. Ch. 32 §2	Clinical timeline
Cross the 30-day cliff	About day 30	Bridge medication ends by taper with follow-up booked. No second withdrawal on top of the first.	Supp. Ch. 31 §8	Kernel projection
Weeks 1–4	Weeks 1–4	GHB taper continues under supervision. Anhedonia is dominant. Exercise is mandatory. The strongest craving is for the meth-sex combination.	Supp. Ch. 29 §3	Kernel projection
Neurochemical rebuilding	Months 1–3	GABA system substantially recovering. D2 receptors progressing. Genuine pleasure returning. Flatline about 1–3 months (meth-primary) or 3–6+ (frequent MDMA).	Supp. Ch. 29 §§3, 5.3	Kernel projection
Consolidation	Months 3–12	GHB track largely complete. Dopamine near baseline. Serotonin baseline recovered. Sexual desire returning.	Supp. Ch. 29 §3	Kernel projection
Receptor recovery	12–18 months	Meth D2 recovery substantial by 12–17 months. GHB receptor recovery 12–18 months or more. Meth-related dopamine repair may run to 24 months.	Supp. Ch. 32 §3; Ch. 31 §2; Ch. 29 §1	Kernel projection
Deep-root reversal	2–5+ years	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Purpose and service. Standing safeguards, including lifelong sexual health care.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: nearest analogs only

The Kernel has no chemsex case study and gives no chemsex-specific projections. Three profiles in Supplemental Chapter 2 are the nearest analogs. Case 10 is a 27-year-old from circuit-party culture using GHB three to four nights a week. Case 05 is a 26-year-old with untreated ADHD using methamphetamine. Case 15 is a 41-year-old with a polydrug history and reward deficiency. Treat these as analogs for each track, not as predictions for a combined pattern, which the Kernel says is more complex than any single one.

Case	Measure	Kernel protocol	Standard treatment
Case 10	GHB cessation at 12 months with the full GABA support stack	63%	20%
Case 10	Anxiety managed without chemical assistance at Month 6	72%	15%
Case 05	12-month meth abstinence with full biological support and ADHD treatment	62%	15%
Case 05	Craving reduction of 50% or more at Month 3 with the full dopamine stack	67%	10%
Case 15	12-month multi-substance cessation with full protocol	55%	8%
Case 15	Significant anhedonia improvement at Month 6	68%	12%
Case 15	No ER or crisis events at 12 months	70%	40%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies and EMCDDA, NIDA, and SAMHSA baselines. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. Case 10 is a frequent user, not someone dosing GHB around the clock, and Case 15 carries the Kernel's caution that 18 months to full stability is not unusual.*

What changes the outcome

- **Stopping GHB abruptly at a dependent level without medical care.** This is the highest-mortality error in the whole guide.
- **Combining GHB with alcohol or ketamine,** or dosing GHB on top of meth, which masks the sedation and delays respiratory arrest.
- **Ending a bridge medication on a calendar date instead of a clinical taper.** The 30-day cliff is a documented relapse point.
- **An open-ended benzodiazepine for post-GHB anxiety** prescribed without knowing the GHB history.
- **Leaving the apps and scene contacts in place,** and leaving weekends unplanned. The craving can arrive at session times months later.
- **Skipping the week-1 sexual health assessment,** or missing PEP's 72-hour window.

- **Ignoring psychosis risk** if there is a personal or family history of psychosis or bipolar disorder.
- **Alcohol as a sleep aid.** It suppresses REM, slows recovery, and risks a second dependence.
- **Treating one substance and ignoring the pattern.** The Kernel says this underestimates the timeline.
- **"A year off, then I will know how to use."** Tolerance is lost and the old pathways return faster than they formed.
- **Testing whether desire has returned,** and expecting sober intimacy to resemble the chemically mediated version.
- **Using alone,** or isolation after exclusion from a venue or community. No one is present to recognize an overdose.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also an overdose-risk event with no antidote for GHB. Do not use alone, call 911 for unresponsiveness, and if you have returned to dependent-level GHB use, go back to supervised detox.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the danger of GHB withdrawal, the absence of an antidote, the masking effect of stimulants, and the fatal combinations in the interaction matrix are well-established clinical facts. The Kernel calls baclofen the most evidence-supported GHB withdrawal treatment and notes there is no FDA-approved treatment for GHB, meth, or cathinone withdrawal. The supplement stack, the peptide layers, the flatline durations, the percentage analogs, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- A complete and honest use history: every substance in the pattern (GHB, GBL, 1,4-BD, meth, each cathinone, and any ketamine, cocaine, or alcohol), how often, the routes (including injection), and whether you dose overnight. The Kernel notes under-reported use leads to under-treated withdrawal.
- Your GABRA2, COMT, MTHFR, and CYP2B6 results, and CYP2C19 and CYP3A4 if known.
- A booked follow-up dated before any bridge medication runs out, and a request for a taper, not a hard stop.
- Any personal or family history of psychosis, schizophrenia, bipolar disorder, or heart conditions, plus any ADHD symptoms.
- A request for HIV, STI, and hepatitis testing, PrEP or ART review, vaccination status, and a chemsex-informed therapist or service.